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A PLEA FOR EARLY OVARIOTOMY.

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A paper with a report of cases, taking the title which Mr. Bantock affixed to his unanswerable little monograph well-nigh a decade ago, seems in the light of progression almost an insult to the intelligence of the Society before whom it is read.

To all operators, recognized as standing in the front rank of abdominal surgery, the defence of early ovariotomy is needless. It is simply now a necessity for those who, not refusing to operate under pressure, although hesitating to do so, are willing to wait until the danger or the discomfort of the patient is so great that she is willing to submit to anything rather than to suffer longer. In this method of dealing with abdominal disease, ignorance and excuse for waiting are veiled by promises and explained by subterfuge, while the disease is duly making progress, and its cure grows more difficult, or perhaps impossible. Who are the men, therefore, who refuse either to assist their patients under the conditions of which we are now speaking, or are unwilling that these patients should have the advice or assistance of others, who hold the sufferers while they grip their fees, and ignorantly or audaciously tamper with human life? The answer resolves itself into this: either having stood, while progress passed them, they are unable to grasp the present, or they are influenced by the base desire to hold patients who may be scared away by suggestion of operation, or having given opinion, they refuse consultation, lest adverse opinion be given and prestige be lost, or else they are unable to diagnosticate the condition, and hence are unable to come to a conclusion concerning it.

I hold, without fear of successful contradiction, that no man, no honest man, should fear a consultation. I do not mean a made-up consultation, one in which the doctors or the surgeons agree, and the patient goes on suffering. That any man is always able to come to an exact knowledge of the condition in abdominal disease, I know is impossible, and two men, however skilful, may fail, yet two men can come, by honest conference, to a conclusion approximately correct, sufficiently exact for the best interests of the patient, which will enable them at least to decide upon the advisability of operative interference, or at least of exploratory incision.

I have among the men who consult with me many who habitually send their patients to me with this request: "Please tell this patient exactly what you think of her case." This is invariably after the doctors themselves have given the patient their own opinion of her condition. I do not hold that this is always safe so far as self-interest is concerned, but it is honest, and sooner or later such treatment of patients must commend itself to the general laity. In an abdominal operation no man, however skilful, has a right to object to or refuse consultation. I have, among my working acquaintances, a number of young men whose diagnosis of abdominal disease is almost uniformly correct, as shown by operation, and yet I have more than once heard these men accused of a desire for operation beyond the necessities of the situation by the very men who, to my knowledge, had failed to determine the presence of serious lesions, even with the advantage of much age and wide experience. The truth is that age does not necessarily have to do with correct diagnosis, neither does experience, simply taken as so many cases. It is the study of these cases, it is the willingness to learn from the experience that has failed and tried again, studying its failures and making them successes. It is the patient work that goes on honestly, day to day, without advertisement and printed handbills. The doc-

trine of procrastination, then, is only preached by those who are ignorant or worse. In no other branch of surgery is this principle followed. A pleurisy is tapped on its discovery, if at all extensive. A stone in the bladder is gotten rid of at once. A broken leg is put in splints. An external wound is sutured. A contracted pelvis is an indication for the early induction of labor, except for those stricken with the cæsarian craze, "the new natural method of delivery." An abscess is at once to be gotten rid of anywhere but in the pelvis. Even the brain is explored and its ventricles tapped without delay. And so on, indefinitely, promptness in action is the law for these men everywhere but in abdominal surgery. There might be some excuse for this view of the question were it commended either by any authority or any common sense outside of authority. When it is taken into consideration that no abdominal growth of long standing can exist without complications, and that these complications are often more serious than the original disease, involving tissue after tissue and lesion after lesion, the persistence of men, who cannot discover disease of the pelvic organs except by post-mortem examination or a condition which soon will necessitate it, in decrying eagerness to operate, and urging waiting is simply a criminal obtrusion of ignorance. Says Mr. Bantock: "Who that has had any extended experience of this operation has not seen cases, far too numerous, in which the patient has been allowed to go on until the operation has become a forlorn hope. I can, unfortunately, quote too many instances of this. Within the last year I have had several cases of the most distressing kind. In one case, the patient was so ill on admission that operation was out of the question, and she died in three to four days. In this case, disease had been recognized for two years. In two, the disease had been of long standing, adhesions were universal, and the patients died from shock in ten and twenty minutes respect-

ively. Two patients died on the table before the completion of the operation—one being moribund at the time of operation."

At the present writing I am asked to operate upon a tumor first seen two years ago. The woman is greatly emaciated and her vital powers at a low ebb, probably a hopeless case.

In the face of these facts, it may be said on the other side that in early operation for ovariotomy, and in pelvic trouble, recovery is the rule, when the patients are otherwise sound. This has been beautifully illustrated by the work of both Bantock and Tait—Tait's record being 146 operations without a death, Bantock's being 86 in the Samaritan Hospital without a death. My own experience is in perfect accord with this. I have never had a death in an early ovariotomy. The deaths have all occurred in seemingly hopeless cases, resulting from delay or neglect.

The report of murderous cases, in the light of our present knowledge, should be an exceptional thing. Their result is so generally fatal, without hope from their very inception, that this alone should urge the necessity of early interference.

An early ovariotomy is the simplest of operations. To enumerate: A short anæsthesia, short incision, non-exposure of viscera, least possible manipulation, freedom from shock, absence of hemorrhage in the absence of adhesions and all complications the result of delay. Now that the subject of gynecology is receiving so much attention, patients consult specialists for the least pelvic discomfort. Hence tumors are fortunately recognized in their incipiency in many cases.

Case I is a case done early—the operation simple, recovery rapid and uneventful. Mrs. K., of Warren, Ohio, white, æt. 52 years, multipara, simple ovarian cyst right side (weight sixteen pounds), no adhesions, one inch incision, trocar, rapid delivery of sac, ligature, no exposure of abdominal viscera, speedy and perfect recovery, neither elevation of temperature nor increase in pulse.

Case II.—Mrs. F., white, æt. twenty-five years, one child three months old, tumor developed immediately after delivery, large simple ovarian cyst right side, no adhesions, short incision, easy delivery, ligature, speedy recovery. Notwithstanding this was a post-puerperal tumor, and the woman in the second month of her second pregnancy, she went to term and was delivered of a living healthy infant without any trouble of any kind ensuing.

Case III.—Mrs. W., of Youngstown, Ohio, white, æt. thirty-two years, multipara, large simple ovarian cyst left side, tumor of two years' growth had been tapped once, no adhesions, removal rapid and simple, speedy recovery.

Case IV.—Miss C., white, æt. thirty years, small simple ovarian cyst right side. This case was complicated by salpingitis on same side and general strong pelvic adhesions of tube and cyst, irrigation and drainage. Rapid recovery.

Case V.—Mrs. K., white, æt. twenty-four, multipara, small parovarian cyst right side, no complications, rapid recovery.

With one exception the cases given above were simple. The general health of these patients was fairly good. None had lost flesh or strength. None suffered pressure symptoms except the one case where there were pelvic adhesions—a condition very liable to occur where removal is delayed, aside from a variety of accidents or changes in structure incident to the development of ovarian cysts—*e. g.*, rupture, twisted pedicle, local or general inflammatory trouble, malignant change. These are typical cases from a large list of consecutive successful early ovariotomies.